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AUTHOR	Leonard, Frances; And Others
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ABSTRACT

The private health financing system in the United States does not meet the needs of much of the population, especially midlife women (aged 35-65). It is no longer possible for anyone but the richest persons to pay for their own health care. This situation developed during the past 3 decades, during which employer-paid health care expanded enormously and health insurance companies assumed the role of provider of health care. During this expansion, however, per capita medical costs rose more than 1,000 percent: doctors' fees rose 700 percent, and hospital costs rose almost 1,000 percent. Now, more and more workers are being left without insurance, as employers balk at the ever-increasing cost of premiums. The plight of midlife women is most acute, because they often lose their group insurance upon divorce or the death of their husbands and cannot get into another group, even if they can afford to pay for insurance, because of preexisting conditions greatly skewed against women by the insurance companies. It is time for the Federal Government to resume the role that it turned over to the insurance companies. A minimally respectable health policy would ensure that all citizens have their medical needs met, either with the full cost supported by taxes or subsidized in such a way that the out-of-pocket cost is not determined by misfortune or chance of disease. The government must act now to insure that persons are not crushed financially by illness or accident. (Includes 37 reference notes.) (KC)

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GRAY PAPER

Health Care Financing And Midlife Women: A Sick System

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Health Care Financing And Midlife Women: A Sick System

In today's medical economy, to be without health insurance is to be without medical care. With hospital daily costs averaging hundreds of dollars, and a routine physical examination approaching $100, it is clear that there is no longer a possibility that individuals, even well-off individuals, can protect themselves from financial catastrophe without public or private insurance. About 33 million Americans (16% of the population) under age 65 are without health insurance, public or private.[1] It is distressing but not surprising to learn that women of all ages are substantially disadvantaged by the system, and that this disadvantage increases with age.

This Gray Paper will focus on the private health financing system in place in the United States and how it has met the needs and expectations of the populace, especially midlife women. (In this paper, "midlife" will mean approximately ages 35 to 65.) Health care financing for persons over 65 is tied to Medicare, Medicare supplement policies, Medicaid and group retirement policies, and includes the crisis in long term care financing. These subjects are not addressed in this Gray Paper.

THE VERY BEST SYSTEM IN THE WORLD?

It is no longer possible for any but the richest individual to pay his or her own medical expenses if even a moderate illness or accident arises. Twenty years ago, before the advent of Medicare and Medicaid and the resulting hyperinflation of medical costs, a person of moderate means could afford to risk going without health coverage. The poor, of course, including a large proportion of the elderly, were at the mercy of public clinics or had no care at all. For the middle income individual, there was a risk that catastrophic illness would cause impoverishment, but catastrophic illnesses or accidents are not everyday affairs, and many felt they could assume that risk and pay out-of-pocket for routine care and moderate illness.

What happened to change that situation? At the urging of President John F. Kennedy, in the early 1960's Congress began a historic and crucial debate over the national direction of assuring access to decent health care for all Americans. Hospitals, physicians, health insurers and chambers of commerce combined in a powerful lobby to oppose any plan to nationalize health care in this country. Discussed and discarded were proposals ranging from a national health service similar to Britain's (where the medical providers were employees of the government) to a nationalized health insurance plan, similar to Canada's (where the providers are independent but paid by the subscribers to the national insurance plan).

This paper was written by Frances Leonard, with contributions from Donna Ambrogi and Alice Quinlan.

These modes were unacceptable to the opposition lobby, who fervently assured Congress that the American system of private providers, paid by individuals who had available to them private health insurance, was the very best system in the world. The lobby acquiesced in permitting passage of Medicare (for the elderly and disabled), and Medicaid (for the very poor), only because those populations were not an attractive market to underwriters. Congress bowed to pressure not to go further. As a result of this Congressional default, the "best system in the world" is duplicated in only one other industrialized country: the Union of South Africa.

But as time went on, large cracks appeared in the system. Medicare and Medicaid, originally greeted with great hostility by the medical community, were enthusiastically embraced by it when the financial bonanza the programs represented became clear. The great infusion of funds into the medical sector through government programs was duplicated in the private sector through the growth of private group insurance obtained through the workplace. Prior to the financing revolution of the 1960's and 1970's, individuals paid most of their medical (non-hospital) bills out of their pockets. This necessarily limited the amount a medical professional could charge the patient. But in these two decades, tax incentives to employers assured the growth of medical fringe benefits for employees, which meant that most individuals no longer paid all of their own costs. This removed the stricture on the physicians' and hospitals' rates, which subsequently soared.

The irony is that instead of assisting elders by lowering their medical costs, Medicare ultimately succeeded mainly in increasing the wealth of the medical community which had opposed its passage. The fundamental policy flaw was allowing medical providers to charge more than the government programs or private insurance would reimburse. In this way, the medical community continued to charge the patient whatever the market would bear, and in addition pocketed the government or insurance payment. A recent study shows that persons over 65 now pay a higher percent of their income for out-of-pocket medical care than before Medicare was enacted.[2] Medicaid, on the other hand, prohibits providers from charging the patient over and above the Medicaid rate, and so has had better success in insulating its claimants from soaring medical costs. It, too, has enriched the medical community by expanding the medical services available to the poor and ensuring their payment.

THE HEALTH INSURANCE UNIVERSE

In the health insurance universe, there are three levels of coverage. The Cadillac is the employment group policy. It is much cheaper than other forms of coverage (generally about one-half the cost, including both the employer and employee share of the premium--which in 1986 usually means a difference of $2000 per year), and provides the most generous benefits. The employee is covered under the plan without exclusion and regardless of medical condition or history. Eight-five percent of all private health insurance written in this country is in employment groups,[3] the vast majority of such policies paying 80% of the average daily hospital rate. This dramatically illustrates the fact that access to health care in this country is through Medicare, Medicaid or a tie to the paid labor force.

A variation on the employment group policy is the "association" group policy, where an organization (such as Older Women's League, American Association of Retired Persons, National Organization for Women) or a fraternal order (Soroptimists, Elks) can cover its members with a group policy. An association group is more costly and has lower benefits than employment groups because, insurers argue, they are voluntary and therefore attract higher risks. Association groups rarely guarantee acceptance, with the result that midlife and older women are often unable to qualify.

Next in quality is the individual policy. Only thirteen percent of health coverage in the country is under individual policies.[4] These policies provide narrow benefits and are considerably more expensive than the employment group policy, often twice as costly. In 1986 an individual policy for a woman of age 50 to 65 often runs $4000 per year. Applicants must qualify medically to be eligible, and pre-existing conditions are commonly excluded.

Finally, the coversion policy comes in at the bottom of the heap. This is a form of individual policy for persons who have been covered by an employment group policy and subsequently lose that coverage through a change in work or family status. Insurers reluctantly write conversion policies. They are offered only as a result of employer insistence or state law, and are even more expensive than individual policies, with minimal benefits. Generally acceptance is guaranteed, with no medical examination or pre-existing conditions excluded. A former group member who can qualify for an individual policy will usually try to do so, rather than settle for the generally inferior and expensive conversion policy.

THE FEDERAL ROLE

Regulating the business of insurance is the business of the states. But there is one major and growing exception. In 1974, Congress passed the Employee Retirement Income Security Act (ERISA), primarily to regulate private pension plans, but also with authority over employers' self-insured health plans, now commonly known as ERISA plans. ERISA plans result when an employer decides to accumulate funds from which employees' health claims are paid. Often this is done by payroll deduction. Employers, especially large ones, can escape state insurance regulations by forming ERISA plans instead of buying commercial plans such as Prudential or Aetna, or Blue Cross or Blue Shield (the Blues) or other coverage, such as health maintenance organizations (HMOs).

Thus if a state had enacted provisions to protect its citizens from exclusion from insurance (for example, by requiring that insurance cover infants or persons suffering from alcoholism or mental illness), an employer could get out from under those requirements by self-insuring under ERISA, and presumably pay less for its employees' coverage. ERISA, in turn, includes scant benefit requirements. It is reported that one third of employment group health policies in the nation today are ERISA plans, and this is a rapidly growing trend.[5] In this Gray Paper, ERISA

plans are not included in the discussion unless noted. Although the Blues and HMOs and certain other species of coverage are not technically "insurance", they will be referred to as such in this paper. The reader should be aware that ERISA plans represent a major and growing hole in our health delivery system.

TOO GOOD TO BE TRUE

By the 1980's, 84% of Americans were covered, at least to some extent, by private and/or public health insurance.[6] Seventy-five percent of full-time workers were covered through their place of work.[7] This extremely popular fringe benefit expanded to include the spouses and children of the employee in most instances. This extraordinary infusion of funds into the medical sector of the economy had a predictable (but nevertheless unpredicted) result.

Hospitals and physicians doubled, then tripled their rates--and the government and private insurers paid. Between 1960 and 1980, per capita medical costs rose more than 1000%--four times the Consumer Price Index[8] --and still the government and insurers paid. During this period, the rate of inflation (as measured by the Consumer Price Index) reached 242%, physicians raised their fees by a stunning 700%, and hospital rates soared 979%.[9] In 1983, medical economists reported that the average physician was netting over $100,000 (after overhead, expenses, malpractice premiums, etc.)[10] and the government and insurers paid and paid.

The best system in the world seemed to be too good to be true. The poor and the elderly were seemingly assured of care through Medicaid and Medicare--were even warmly courted by physicians and hospitals hungry for federal dollars. Insurers were energetically signing up group after group and watching the premiums pour in. States were attracting large revenues through premiums taxes. For-profit hospital chains came into being and were an investor's dream. Non-profit or voluntary hospitals expanded and and extended their services. Doctors were getting rich. Employers were able to provide their employees with a valued benefit for less dollar outlay than wage increases. And best of all, employees and their families received medical treatment without having to pay most of the cost!

With this third-party payor system in place, the doctor and patient decided between them what the treatment would be, and the unconsulted insurer would have to pay up. There was no incentive for either the doctor or the patient to seek less costly alternatives, nor for the patient to seek another opinion. By 1985, almost 11% of GNP was spent on health care, compared to 5.3% before Medicare and Medicaid began.[11] Americans were spending $149 billion annually on health costs,[12] one-half for persons over 65.[13]

THOSE LEFT OUT IN THE COLD

The "best system in the world" has driven medical costs so high in the short twenty years since its inception that the sleeping giant has finally awaken. It was awakened by the importunings of the unemployed, who during lay-offs and recessions lost access to health care through loss of their

job-related group insurance. It heard pleas from pediatricians who noted that the customary neonatal exclusion in private plans (excluding newborns from the policy benefits for the first thirty days of life) was costing lives as new parents failed to bring in their new babies because of cost.

Through the efforts of advocates, the unemployed and newborns now have some protection under law. But other groups are still struggling to obtain coverage. Ethnic and racial groups complain that hereditary conditions such as Tay-Sachs and sickle cell trait are excluded from policies; women exposed to DES therapy in the 1940's and 1950's (and their progeny of both sexes) are usually excluded. Parents of developmentally disabled children point out that their children are dropped from the policies when they reach the age of majority, despite lifelong dependency that many of them will experience. Persons with chronic conditions such as diabetes, Parkinson's disease, multiple sclerosis and others are usually excluded altogether, or else their condition is. Women are outraged to learn that human reproduction is usually their cost burden alone. Commonly excluded from insurance coverage are such health needs as pregnancy, childbirth, contraception, breast prostheses, abortion, sterilization, pap tests, miscarriage, breast reconstruction and caesarian sections.[14] Policies which do include some of these areas often offer them only to married women.[15] Well-baby check-ups in the first year of life are almost universally excluded by commercial carriers and the Blues, with the result that struggling young families are often forced to skip these crucial visits. Psychiatrists complain that their business suffers because mental health benefits are limited or excluded. Chiropractors, acupuncturists, nurse midwives, and other alternative practitioners are generally out in the cold.

As more and more ordinary citizens have found themselves shut out of the system, a realization has emerged that medical economics has changed since the mid-1960's. Because of the horrendous rate and fee increases in the medical sector (that is, net increases not ascribable to defensive medicine or burgeoning malpractice awards), it is no longer possible for middle-income persons to finance their own medical care.

SPECIAL PROBLEMS OF MIDLIFE WOMEN

Midlife women have found that a change in marital status--from married to divorced or widowed--means ejection from the group coverage they had through their husband's place of work. Divorced women are twice as likely as married women to be without health coverge,[16] and their numbers continue to grow due to the staggering increase in midlife divorce occurring after the advent of no-fault divorce status in the 1970's.

To meet this crisis, the Older Women's League launched an effort to change state laws so that groups would be compelled to continue the former spouse in the group until she qualified for a policy of similar worth or for Medicare at age 65. A model bill was developed, and three years of effort at the state level resulted in enactment of laws in several states which mandated continued coverage. However, with only two exceptions, the continuation period was only six months to a year. OWL met with the stiffest possible opposition from the health insurance industry, and received no support from the medical community.

Finally, through an effort spearheaded by OWL, federal legislation was passed which enables former dependents to remain in the group (paying their full share) for up to three years.[17] The immense amount of effort it took to secure this small benefit was instructive. After all, no tax funds are involved, nor is the employer or insurer asked to subsidize the premium. Beneficiaries will pay both the employer's and the employee's share. Already group members, they do not represent an actuarial unknown. Yet the industry bias against midlife women has made it appear they were being asked to insure a monster.

Many women become uninsured through gender-determined roles of dependency, such as career homemaking. Other women, again because of gender-assigned work roles, work in part-time or marginal jobs with no fringe benefits.[18] More than one-quarter of the women in the paid labor force are part-time workers, and only 42% of the employers who offer health insurance benefits to their full-time workforce also offer it to their part-time workers.[19] Even full-time women workers are more likely to be in jobs offering no health insurance than are men, because the non-unionized service sector, which employs the vast majority of women, is least likely to offer fringe benefits.[20]

Frantic searching for an individual policy which will accept them too often proves fruitless. Either an existing condition will be excluded, or the entire application will be rejected. Research has established that women are more likely than men not to have health insurance in their own right, or not to have the $2000 to $4000 for the annual premium.[21] The result is that over 40% of unemployed divorced women rely on Medicaid, compared with only 4.5% of unemployed married women.[22] The latter, of course, generally are included on their husband's employment group policy.[23] Almost half of unemployed widows between the ages of 35 and 64 and two-thirds of unemployed divorced women fail to obtain private health insurance.[24]

Ironically, often a health-conscious woman of age thirty or so will live to rue her obedience to the laudable exhortations of the health establishment calling for an annual pap test and breast examination. Ten such annual visits in the decade of her twenties will very likely turn up a benign breast lump or cervical lesion which, although established not to be a predictor of future problems, will nevertheless disqualify her from obtaining individual health coverage. Her twin brother, with an equivalent state of health, will likely not have visited a doctor during his twenties, and so will present a clean record for insurance purposes.

Thus women over age thirty face threats of loss of health coverage unique to their status as women: dependency status exposes them to loss of group insurance due to the loss of the marriage (death or divorce); part-time and marginal employment provides no health fringe benefits; and insurers' bias against common benign female conditions can result in total denial of coverage or exclusion from coverage of ordinary reproductive functions or ailments.

Once excluded from the employment group policy, one must begin the frustrating search for individual coverage. For a midlife woman who has

not yet reached 65 (when most become eligible for Medicare), this can be a painful search indeed. If she is eligible for a conversion policy after leaving the group, she is wise to sign up for it as interim protection while she searches for better coverage. Even if she believes the policy to be ridiculously limited and/or too costly, it may turn out to be all she will be eligible for.

In seeking either a conversion policy or an individual policy for which she qualifies medically, a woman will note that premiums are usually classified by age, sex and sometimes region of residence. Women under age 50 pay far higher premiums than men of the same age. At age 50 to 55 rates between men and women begin to equalize, with men's premiums outpacing women's from the mid-50's until Medicare eligibility at age 65, when most Medicare supplement policies use unisex rates, that is, the same rate for men and women. If the battle to eliminate gender discrimination in all insurance rates (auto, life, health and annuities) is won, midlife women would lose their health insurance rate advantage over men of the same age. However, over a woman's lifetime this ten year advantage would be more than offset by equalizing rates in her earlier years. The myth persists in the public mind (and in the minds of many insurance spokespersons as well) that midlife women represent the highest risk category. A glance at rate charts of the underwriters readily establishes that the costs of the more catastrophic illnesses of midlife men outweigh the more frequent milder ailments of midlife women.

If they do not qualify for an individual policy or cannot obtain a job with a good health plan, many women join an organization which offers "association" group coverage. The principal problem for a midlife woman is that most of these policies offer neither guaranteed acceptance nor age-blind rates. A policy which retains the right to exclude an applicant altogether, or which applies rigid pre-existing conditions exclusions, is discriminatory against its older, female applicants.

The inability of women to obtain access to adequate health care through the prevailing system of private health insurance obtained through employment is an important factor in the feminization of poverty. Two-thirds of those receiving Medicaid (medical care for the needy) are women.[25]

DISSATISFACTION SPREADS BEYOND THE CONSUMER

Individuals are not the only ones dissatisfied with the existing system of assuring medical care. As the medical community's rates and fees soar, insurers have increased their premiums dramatically. Beginning in the late 1970's, employers have tried to cut back on health coverage as a fringe benefit. Employees have either found themselves paying higher premiums, deductibles and co-payments, or else their benefits have been diminished or eliminated altogether. Employers and employees have thus joined the underinsured and excluded in their dissatisfaction with the system.[26]

Insurers, as well, have joined the disenchanted. Dramatic increases in premiums have forced employers to cut back, which has eroded the primary market: employment groups. Self-insured plans (under the federal

ERISA legislation described earlier) are an increasingly popular alternative for many employers, thus diminishing the market for commercial insurers even further. Some underwriters have left the health insurance business altogether.[27]

As consumers, employers, labor unions, state and federal health agencies and insurers recognized their growing problem, a common effort to contain medical costs has emerged. Not composed of natural allies, the "coalition" remains an uneasy one. The interest groups warily circle one another, each putting forth its own candidate for the burden of increased cost. Should insurers cut their profits? Should consumers pay more out of their pockets? How about employers assuming more of the cost? Perhaps increased government subsidies? Each constituency argues vigorously that the sacrifices should fall elsewhere.

Consumers point out that they already pay more out-of-pocket costs than health policymakers deem prudent. For Americans under 65, private insurance pays only 46% of medical costs.[28] For those over 65, Medicare now pays about 44% of costs.[29] The Department of Health and Human Services considers that an individual has "adequate" health coverage if no more than 10% of his or her annual income is spent out-of-pocket on medical costs.[30] Using this standard, HHS has found that almost 24% of the citizenry will have to spend more than 10% of their annual income to cover the expenses of a moderate illness.[31] For the smaller risk of a catastrophic illness, 37% of the nation will pay more than 10% of their annual income from their own funds.[32]

Not surprisingly, the exposure to this risk of loss is not borne equally by men and women. For the moderate illness, 25% of male headed households will exceed the 10% share of cost, while almost 40% of female headed households will.[33] This emphatically illustrates one more gender bias in the existing system. It also makes clear that by the government's own standards, a substantial percentage of Americans are paying more of their income for health care than good policy dictates.

If the consumer is already bearing more of the medical expenses than policymakers feel is prudent, perhaps the employer should absorb the costs? Not likely, since the **UNFUNDED** health cost liability for the 500 largest American companies have reached $2 trillion, while the total assets of those companies is less than $1.3 trillion.[34] This means that if all the claims that the businesses are legally required to cover should come due, even full liquidation of the 500 largest American companies would not cover the costs. Health insurance coverage costs to employers have been rising at a rate of 25% per year in recent years.[35] Employers will not volunteer to increase their share.

Perhaps the insurance companies could cut some fat? No takers there, either. Insurers since the early 1980's have been reaping the unhappy harvest of investment mistakes made a decade earlier. Declining numbers of them are even writing health insurance policies.[36]

Having eliminated all other candidates for cost increases, the two remaining candidates for remedial measures are the government (through

increased tax-supported coverage for all citizens) or the providers (by capping the rates and fees of the hospitals and/or the practitioners). Focused on eliminating the federal deficit, the government has declined to be the goat, thus beginning in the early 1980's a trend towards freezing and containing medical costs. At this juncture physicians and hospitals join consumers and payors in their dissatisfaction with the existing health delivery model, and the nation now stands at the threshold of a major restructuring of the system.

WHAT NOW?

As stated earlier, the United States is the only industrialized nation besides South Africa which does not provide a national health plan for its citizens. Access to health care is a fundamental human right. Any government which derives its legitimacy from the consent of the governed must assure its citizens this basic human need. A presidential commission recently affirmed this obligation when it stated: "Society has an ethical obligation to ensure equitable access to health care for all."[37] To the extent, then, that our system is not all inclusive, it has failed its vital function.

The promise made in the 1960's--that private insurance, coupled with private medical providers, would stand in for the government and provide the best possible care for all Americans--has not been realized. Insurers to this day insist on their "private enterprise" right to exclude from coverage whomever they determine to be a bad risk. Physicians insist on their right to serve whomever they will, and to charge whatever they can get. The result has been wholesale exclusions or increased premiums by disease category, by gender, by age, by geographical location and now--with the AIDS crisis--by marital status and occupation. People have been pitted against each other in the most despicable manner. Alzheimers' groups, diabetes groups, AIDs advocates, renal disease victims, the developmentally disabled, persons with cystic fibrosis, cancer--all lobby legislatures stating that theirs is the most pitiable of all possible conditions, in the wan hope that some subsidy might be wrung from the government in order to serve their most basic need for medical care.

The government's answer has been welfare. When insurers abdicate, Medicaid is the result in many cases. Individuals must impoverish themselves first. Once the assets have been sold to pay for the medical care, then the government steps in. But even here, the midlife woman finds herself without a safety net. In most states, unless she has minor children in her custody or is blind, disabled or over age 65, she will be ineligible to receive Medicaid, even if her income and assets are zero! She will be relegated to the county hospital or other public clinic, and subject to the wide variance in regulations and services each locality provides.

This is an outrage.

A minimally respectable health policy would ensure that all citizens have their medical needs met, either with the full cost supported by taxes, or subsidized in such a way that the amount borne out-of-pocket is

not determined by misfortune or chance of disease. Under our existing system, no individual can be certain he or she will not be financially crushed by accident or illness sometime in life. There is always that specter--the possibility of becoming uninsurable. This is a contingency that no amount of prudence or foresight can prevent. The fact that this burden is borne unevenly by American citizens is unconscionable. When one's lifetime medical costs, including insurance premiums, are determined by gender, geographical location, age, sexual orientation, marital status and other individual characteristics, one begins to question the equal protection of the law--or at least the equal protection of public policy.

Whether this will be accomplished through government-run health services (in the manner of the public schools, where the facilities are government owned and the employees work for the government), or through a national health insurance plan (which covers everyone and everything, but with independent hospitals and medical professionals) will depend in the end on politics. There are models for each system well established all over the world.

But American medical providers and insurers continue to insist on their free enterprise right to discriminate among Americans on the basis of personal characteristics. In this assertion they are plain wrong. Medicine ceased operating under free market conditions when physicians obtained monopolistic licensing laws. This process accelerated throughout the first half of this century as organized medicine increased its strength and obtained statutes and regulations to guarantee its monopoly of medical care. Insurers, of course, have been heavily regulated by the states in the wake of outrageous abuses while operating under free enterprise.

When medicine and insurance persuaded Congress to turn the country's medical system over to them, they became the government's delegates--nothing more. In effect, Congress gave them the contract to carry out this function of government. The lucrativeness of that contract is beyond dispute. If they cannot peform the contract at a fair price, if they cannot do so without discriminating against millions of Americans, then they have breached the contract. Free enterprise has no relevance here; medicine and insurance abandoned free enterprise when they negotiated this heavily tax-subsidized arrangement with Congress.

As surrogates of the government, insurers and providers must respond to the needs of the populace. When they do not, the government must act. When the government will not act, then the system is no longer legitimate.

We have arrived at that point.

NOTES

1. Health Insurance Association of America, Sourcebook of Health Insurance Data, (1982-1983), p. 7

2. NEWS, House Select Committee on Aging, FACT SHEET, July 30, 1985.

3. Department of Health and Human Services, National Health Care Expenditure Study, "Unemployment, Health Insurance and Medical Care Utilization", November 3, 1983.

4. See note 1, p. 25.

5. Ibid., p. 8.

6. Ibid., p. 7.

7. Committee Print, Committee on Finance, United States Senate, Health Benefits: Loss Due to Unemployment, (April 1983), p. 2.

8. Congressional Record, March 13, 1984. Statement of Senator Edward M. Kennedy upon introduction of S 2424, The Medicare Solvency and Health Care Financing Act of 1984.

9. House Select Committee on Aging, Corporate Retirement Benefits: Here Today, Gone Tomorrow?, briefing paper, June 27, 1984, p. 4.

10. Survey taken by Roth Young Personnel Service, Inc., a medical personnel recruitment organization, in 1983.

11. Statement issued by Senator Edward M. Kennedy before the introduction of S 2424 (see note 8), February 1984.

12. Ibid.

13. Women and Health, v. 8(4), Winter, 1983, p. 88.

14. Ibid., p. 80.

15. Ibid., p. 79, 81.

16. American Journal of Public Health, "Women and Divorce: Health Insurance Coverage, Utilization and Health Care Expenditures," November, 1984, p. 1276.

17. Public Law 99-272, Title X, requires continuation for unemployed workers and dependents for up to 18 months; and continuation for widows, divorced spouses, Medicare-ineligible spouses of certain retirees, and their dependents for up to 3 years.

18. See note 13, p. 78.

19. Ibid., p. 78.

20. See note 7, p. 3.

21. See note 13, p. 77.

22. See note 16, p. 1276.

23. Ibid., p. 1276.

24. Ibid., p. 1276.

25. See note 13, p. 84.

26. See note 9, p. 1.

27. Interview with Brad Wenger, Association of California Life Insurance Companies, February 1986.

28. See note 13, p. 77.

29. See note 11.

30. Health and Human Services, National Center for Health Services Research, November, 1984, (study conducted by Pamela J. Farley).

31. Ibid.

32. Ibid.

33. Ibid.

34. See note 9, p. 1.

35. Ibid., p. 4.

36. See note 27.

37. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Securing Access to Health Care, Volume One, 1983, p. 4.